Lake Washington School District #414
Health Services

EPINEPHRINE ADMINISTRATION AUTHORIZATION AT SCHOOL

Student's Name: ____________________ Birthdate:__________

School:____________________ Grade: ____________

This section to be completed by Health Care Provider

Identified Allergen(s): ____________________

Medication: EPINEPHRINE Strength: 0.3mg ☐ 0.15mg ☐ _____mg ☐

Dose: 0.3mL ☐ 0.15mL ☐ _____mL ☐ Route: INTRAMUSCULAR

If second pen prescribed, length of time between doses: ____________________

If approved by school, can student self-carry and self-administer medication? Yes: ☐ No: ☐

Follow up care: Call 911

I authorize administration of epinephrine for suspected exposure to allergen or signs of anaphylaxis. This student has a life-threatening allergy that requires the administration of epinephrine. A district RN may not be available to administer this epinephrine or to assess the progression of symptoms. Epinephrine may be given by a designated staff member trained by the school RN. If epinephrine is administered 911 will always be called.

____________________ ____________________
Health Care Provider Signature (no stamps) Date

____________________ (   ) ____________________
Printed Name Phone Number

This section is to be completed by Parent/Guardian

As the parent/guardian I understand the following:

- I authorize the school to administer epinephrine as indicated above.
- It is my responsibility to replace an expired or used epinephrine auto injector.
- This authorization is valid only for the current school year, which includes summer school.
- If exposure to the allergen identified above is suspected, the epinephrine will be administered and 911 will be called.

____________________ ____________________
Signature Parent/Guardian Date

____________________ (   ) ____________________
Printed Name Phone Number